DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 03-014

2. STATE: South Carolina

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2003

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447, Subpart C

7. FEDERAL BUDGET IMPACT: *$36,100 x 75% x 72.81%
$36,100 x 25% x 69.86%
a. FFY 2004 $26,018*
b. FFY 2005 Rates will be rebased

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-D, Pages 3, 6, 8, 12-15, 17, 18, 21, 22, 25, 26, 28

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-D, Pages 3, 6, 8, 12-15, 17, 18, 21, 22, 25, 26, 28

10. SUBJECT OF AMENDMENT:
Rates for nursing facilities effective October 1, 2003.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Robert M. Kerr

14. TITLE:
Director

15. DATE SUBMITTED:
October 20, 2003

16. RETURN TO:
South Carolina Department of Health and Human Services
Post Office Box 8206
Columbia, SC 29202-8206

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: OCT 20 2003

18. DATE APPROVED: MAY 26 2004

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: OCT - 1 2003

20. SIGNATURE OF REGIONAL OFFICIAL:
Burton Smith

21. TYPED NAME: Charlene Brown

22. TITLE: Deputy Director, CMSO

23. REMARKS:

FORM HCFA-179 (07-92)

E) All nursing facilities are required to retain all financial and statistical records for each cost reporting period, which are accurate and in sufficient detail to substantiate the cost data reported for a period of at least six (6) years following the end of the contract period for which the cost report was used to set this rate. These records must be made available upon demand to representatives of the Medicaid Agency, or the State Auditor, or the Centers for Medicare and Medicaid Services. The Medicaid Agency will retain all cost reports for six (6) years after the end of the contract period for which the cost report is used to set the rate. If any litigation, claim, negotiation, or other action involving the records has been started before the expiration of the six (6) year period, the records shall be retained until completion of the action and resolution of all issues which arise from it, or until the end of the regular six (6) year period, whichever is later.

F) Allowable costs shall include all items of expense which Providers must incur in order to meet the definition of nursing facility services as detailed in 42 CFR 440.40 and or 440.150 as promulgated under Title XIX of the Social Security Act, and in order to comply with standards for nursing facility care in 42 CFR 442 and in order to comply with requirements of the State Agency for establishing and maintaining health standards under the authority of 42 CFR 431.610 and in order to comply with any other requirements for nursing facility licensing under the State law.

1) Allowable costs are determined in accordance with Title XIX of the Social Security Act, 42 CFR USCA 1396, et seq. and Federal Regulations adopted pursuant to the Act; the Medicaid Agency regulations; Title XVIII of the Social Security Act, 42 CFR USCA 1395 et seq., Federal regulations adopted pursuant thereto and HIM-15, except those provisions which implement Medicare, retrospective, as opposed to Medicaid's prospective, reimbursement system or those provisions which concern the relationship between the provider and Medicare intermediary or are modified by this Plan.

2) Bad debts, charity and courtesy allowance shall not be included in allowable costs except that bad debts that are attributed to cost sharing amounts as defined in 42 CFR 447.50 and 447.59 shall be allowable.

3) Allowable cost shall be categorized as follows: (The application is defined in Section III, Payment Determination).

Since the return on capital payment is provided as an incentive for the expansion of Medicaid services by the private sector, only those facilities that were established as profit earning centers were selected for the calculation of the base period costs. Non-profit facilities were excluded from the base period calculation.

2) Inflation Adjustment To Current Period "Deemed Asset Value"

The plan uses the index for the rental value of a home computed as part of the CPI as the appropriate measure for approximating the increase in the value of nursing home assets in South Carolina since 1980-1981. This index measures the increase in the amount that homeowners on average could get for renting their homes. For the period from 1980-1981 through the federal cost year 2000-2001, this index rose 155.013 percent.

Inflating the base period market value of $15,618 by the index for homeowner's rent, the "Deemed Asset Value" for cost year 2001-2002 is $39,828 per bed and will be used in the determination of nursing facility rates beginning October 1, 2003.

3) Calculation of "Deemed Depreciated Value"

The plan will exclude depreciation payments already received by operators from the Deemed Asset Value on the theory that the depreciation charges represent a reasonable valuation of the decline in the worth of the assets from old age. The result is the "Deemed Depreciated Value."

For a facility existing prior to July 1, 1989, the plan will continue to reimburse for actual depreciation costs based on a straight line apportionment of the original cost of the facility and the actual value of any additions. Effective October 1, 1990, for new facilities established or new beds entering the Medicaid Program on and after July 1, 1989, depreciation payments will be set based on actual construction costs, or the Deemed Asset Value when the facility begins operations, whichever is lower, and on applicable Medicare guidelines for depreciation. However, building depreciation for all new facilities/new beds on line on or after July 1, 1991 will be assigned a useful life of 40 years. Accumulated depreciation to be used to offset the deemed asset value for new facilities will be based on accumulated allowed depreciation (i.e. the lesser of actual depreciation or that determined by the Deemed Asset Value).

For bed increases of less than 50% (i.e. no six months cost report is filed), recognition of capital costs will be made at the point in time these beds are certified for Medicaid participation. Furthermore, that portion of the cost of

could be raised by borrowing from the banks. But this would be rather costly for the small investor, who would probably have to pay a rate of interest in excess of the prime rate.

The plan sets the rate of return for a fiscal year at the average of rates for thirty year Treasury bonds (through 2001) and the long-term average of Treasury rates longer than 25 years (effective 2002) for the latest three completed calendar years prior to the fiscal year, as determined by the Division of Research and Statistics of the Budget and Control Board, based on latest data published by the Federal Reserve. Effective October 1, 2003, this rate is 5.61%.

Acknowledging a newly constructed facility's plight of high per bed construction costs and interest rates as great and greater than the market rate of return, the rate of return for these facilities will be the greater of the interest rate incurred by the facility or the industry market rate of return as determined by the Budget and Contro Board. These facilities will only be allowed their interest rate (if greater) during a transition period which is defined as the rate period beginning with the facility's entrance into the Medicaid program and ending at that point in time in which the facility files its first annual FYE September 30 cost report that will be used to establish the October 1 rate (i.e. period ends September 30). In no circumstances will the allowed interest rate exceed 3% above the industry market rate of return.

5) Additions To Facilities After 1981

The plan intends to provide adequate incentives for the expansion of nursing home services by the private sector of the state. The Deemed Depreciated Value takes into account the wearing out of facilities, but does not include any factor for additions or upgradings to the facilities. Operators who have made capital improvements to their facilities since 1981 are permitted to add the amount of the investment to their Deemed Asset Value. Operators are also permitted to add the cost of future additions and upgradings of facilities to their Deemed Asset Value. This provision will provide an incentive to operators to reinvest part of their cash flow back into the facility to maintain and improve the level of service provided by the operator. For clarification purposes, capital expenditures incurred by new beds on line on or after July 1, 1989 during the initial cost reporting period will not be considered as improvements, but as part of actual construction costs.

6) Computation of Cost of Capital

The cost of capital for each patient day served would be calculated for each nursing home based on the Deemed Asset Value. The computation of the rate of reimbursement for the cost of capital is illustrated below in Table 1 for the

a) Depreciation expense of the prior owner.

b) Interest expense which will be limited to the prior owner's expense.

c) Prior owner's equity in the facility.

However, in the event of a sale or lease on and after July 1, 1989, the provider's (new owner) capital related cost will be limited to the cost of capital reimbursement received by the prior owner (i.e., cost of capital payment for the new owner will be the same as the old owner). No revaluation of assets will be recognized by the South Carolina Medicaid Program as a result of a sale.

No recapture of depreciation will be necessary from the prior owner unless the prior owner used accelerated depreciation in excess of the allowable straight line depreciation, or depreciation was overstated over the allowable straight line depreciation because of the application of a shorter useful life in calculating the depreciation.

II. Auditing

A) All cost reports will be desk reviewed by the Medicaid Agency. The Provider will be notified of the desk review exceptions and the provider has the right to respond within fifteen (15) days.

B) All cost reports are subject to on-site audit. Any overpayments determined as a result of on-site audits will be collected after issuing the final audit report and accounted for on the HCFA-64 report no later than the second quarter following the quarter in which the final audit report is issued. The provider has the right to appeal the final audit decision through the appeal process. The appeal decision will be binding upon the SCDHHS.

III. Payment Determination

The rate cycle will be October 1 through September 30 and will be recomputed every twelve (12) months, utilizing the cost reports submitted in accordance with Section I, Cost Finding and Uniform Cost Reports, of the Plan.

For the state fiscal years beginning July 1, 2003 and ending June 30, 2005, funding for the implementation of the October 1, 2003 Medicaid nursing facility rates has been provided by intergovernmental transfers received from qualifying non state owned public nursing facilities via the Essential Public Safety Net Nursing Facility Supplemental Payment Program. This funding arrangement, as allowed by the Centers for Medicare and Medicaid Services, sunsets on July 1, 2005. Therefore, in the event that funds are not appropriated by the South Carolina General Assembly to replace these funds effective July 1, 2005, future Medicaid nursing facility rates will be adjusted and limited to the January 1, 2003 Medicaid nursing facility rates annual expenditure level.

A. REIMBURSEMENT METHODOLOGY TO BE USED IN THE CALCULATION OF THE MEDICAID REIMBURSEMENT RATES

A prospective rate shall be established for each nursing facility separately based on the facility's cost report, and upon the standard costs which are developed in accordance with the methodology described below. In the event that audit adjustments are made to cost reports in accordance with Title XIX and Title XVIII Program rules, regulations, policies and procedures, the rate of payment will be established so as to be consistent with the facility's cost as audited. In the event that such adjustment is made subsequent to the date that a facility was paid an incorrect rate based on unaudited costs, the facility will be liable to repay to the South Carolina Department of Health and Human Services the difference between the audited rate and the interim rate for the contract period. In a case in which an audited rate exceeds the interim rate, the South Carolina Department of Health and Human Services will be liable to repay the facility the difference between the audited rate and the interim rate for the contract periods beginning on or after October 1, 1994.

Effective October 1, 1995, nursing facilities which do not incur an annual Medicaid utilization in excess of 1,000 patient days will receive a prospective payment rate which will represent the average industry rate at the beginning of each rate cycle. The average industry rate is determined by summing the October 1 rate of each nursing facility and dividing by the total number of nursing facilities. This rate will not be subject to change as a result of any field audit, but will be subject to change based on the lower of cost or charges test to ensure compliance with the state plan.

Minimum occupancy levels of 96% are currently being utilized for Medicaid rate setting purposes. However, for nursing facilities located in counties where the county occupancy rate is less than 90% based upon the FYE September 30, 2002 cost report information, the SCDHHS will employ the following policy effective October 1, 2003:

- The SCDHHS will waive the 96% minimum occupancy requirement used for rate setting purposes for those nursing facilities located in counties whose occupancy is less than 90%. However, standards will remain at the 96% minimum occupancy level.
- The SCDHHS will calculate the affected nursing facilities' Medicaid reimbursement rate based upon the greater of the nursing facility's actual occupancy or the average of the county where the nursing facility is located.
- In those counties where there is only one contracting nursing facility in the county, the nursing facility Medicaid reimbursement rate will be based upon the greater of the nursing facility's actual occupancy or 85%.

Rate Sheet

SC: MA 03-014
EFFECTIVE DATE: 10/01/03
RO APPROVED: MAY 26 2004
SUPERSEDES: MA 02-006

Effective October 1, 1995, for the purpose of establishing all cost center standards, the facilities are grouped according to bed size. The bed groupings are:

0 Through 60 Beds
61 Through 99 Beds
100 Plus Beds

A. ALL STANDARDS, EXCEPT FOR GENERAL SERVICES, FOR PROPRIETARY AND NONPROFIT FACILITIES (EXCLUDING STATE OWNED) WILL BE COMPUTED USING PROPRIETARY FACILITIES ONLY. EFFECTIVE OCTOBER 1, 1997, HOSPITAL BASED PROPRIETARY NURSING FACILITIES WILL BE EXCLUDED FROM THE COMPUTATION OF ALL STANDARDS, EXCEPT FOR GENERAL SERVICES. THE GENERAL SERVICE STANDARD WILL BE COMPUTED USING PROPRIETARY AND NONPROFIT FACILITIES (EXCLUDING STATE OWNED). A BRIEF DESCRIPTION ON THE CALCULATION OF ALL THE STANDARDS IS AS FOLLOWS:

1. General Services:

   a. Accumulate all allowable cost for the General Services cost center (Nursing & Restorative) for all facilities in each bed size.

   b. Determine total patient days by multiplying total beds for all facilities in each group by (365 x 96%).

   c. Calculate the mean cost per patient day by dividing total cost in (a) by total patient days in (b).

   d. Calculate the standard by multiplying the mean by 105%.

   e. The establishment of the General Services standard for all nursing facilities (excluding state owned facilities) will be based on the average of the percentage of Medicaid Level A patients/total Medicaid patients served. Rates effective on or after October 1, 2000 will be computed annually using the DHHS Aries report reflecting nursing facility utilization by patient acuity based upon the preceding July 1 through June 30 data period. Effective October 1, 2003, co-insurance days for dual eligibles are excluded from the computation. The General Services standard for each separate facility will be determined in relation to the percent of Level A Medicaid patients served, i.e., the base standard determination in (d.) above will be decreased as the percent of Level A Medicaid patients is decreased and increased as the percent of Level A Medicaid patients is increased.

4. For costs not subject to standards, the cost determined in step 2 will be allowed in determining the facility's rate.

5. Accumulate costs determined in steps 3 and 4.

6. Inflate the cost in step 5 by multiplying the cost in step 5, by the inflation factor. The maximum inflation factor that can be used will be that provided by the State of South Carolina Division of Research and Statistical Services and is determined as follows:

   a. Proxy indices for each of the eleven major expenditure components of nursing homes, (salaries, food, medical supplies, etc.) during the third quarter of 2003 were weighted by the expenditure weights of the long term care facilities. These eleven weighted indices are summed to one total proxy index for the third quarter of 2003.

   b. Proxy indices are estimated for each of the eleven major expenditure components of nursing homes, (salaries, food, medical supplies, etc.), during the third quarter of 2004 and then weighted by the same expenditure weights as in step a. These weighted proxy indices were summed to one total proxy index for the third quarter of 2004.

   c. The percent change in the total proxy index during the third quarter of 2003 (as calculated in step a), to the total proxy index in the third quarter of 2004 (as calculated in step b), was 4.7%. Effective October 1, 2003 the inflation factor used was 4.7%.

7. The per patient day cost of capital will be calculated by dividing capital cost as determined under IF(C) of this plan by actual patient days. However, if the facility has less than 96% occupancy, actual days will be adjusted to reflect 96% occupancy.

8. Cost Incentive - General Services, Dietary, and Laundry, Housekeeping, and Maintenance

   If the facility's actual allowable costs for these three cost centers are below the sum of these three allowable cost standards, the facility will be eligible for a cost incentive of an amount equal to the difference between the sum of the standards and the sum of the facility's actual costs, up to 7% of the sum of the standards.

9. Profit will be allowed if the provider's allowable cost is lower than the standard as follows:

   a. Administration and Medical Records & Services - 100% of difference with no limitation.

Ceiling on profit will be limited to 3 1/2% of the sum of the provider's allowable cost determined in step 2. The sum of the cost incentive and the profit cannot exceed $1.75 per patient day.

10. For rates effective October 1, 2003, the provider's reimbursement rate under this concept will be the total of costs accumulated in step 6, cost of capital, cost incentive, and profit.

B. Payment for Hospital-based and Non-profit Facilities

Hospital-based and non-profit facilities will be paid in accordance with Sections III A, B, and C.

C. Payment determination for a new facility, replacement facility, change of ownership through a purchase of fixed assets, change of ownership through a lease of fixed assets, when a facility changes its bed capacity by more than fifty percent (50%), or when temporary management is assigned by the state agency to run a facility.

1. Payment determination for a new facility or a facility that changes its bed capacity by more than fifty percent (50%):

The following methodology shall be utilized to determine the rate to be paid to a new facility or a facility that changes its bed capacity by more than fifty percent (50%):

Based on a six (6) month's projected budget of allowable costs covering the first six months of the Provider's operation under the Medicaid program, the Medicaid agency will set an interim rate to cover the first six (6) months of operation or through the last day of the sixth (6^{th}) full calendar month of operation. The same rate setting methodology previously described will be applied to the provider's allowable costs in determining the rate except that all standards to be used will be one hundred twenty percent (120%) of the standards for the size of facility to adjust for lower initial occupancy. The one hundred twenty percent (120%) adjustment is determined by considering the average eighty percent (80%) occupancy for the first six (6) months of operation of a new facility versus the minimum of ninety-six percent (96%) occupancy required for all facilities that have been in operation for more than six (6) months.